		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 S. Prairie (Number) Bloomingdale, IL (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630)529-2018 **Fax #** (630)529-9128

IDPA ID Number: 36-2652532

Date of Initial License for Current Owners: 10/1/68

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501-(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Lisa Lipira **Telephone Number:** (630)529-2018 Ext. 2232

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/00 to 6/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Joel Rusco
(Title) President & CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/11/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	30,421	1,460		31,881	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,421	1,460		31,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.05%

D. How many bed-hold days during this year were paid by Public Aid?
882 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/1/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/00-6/30/01 Fiscal Year: 7/1/00-6/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	186,576	14,528	16,054	217,158		217,158		217,158			1
2	Food Purchase		222,348		222,348		222,348		222,348			2
3	Housekeeping	103,617	33,503		137,120		137,120		137,120			3
4	Laundry	50,508	21,756		72,264		72,264		72,264			4
5	Heat and Other Utilities			135,487	135,487		135,487		135,487			5
6	Maintenance	74,969	26,884	60,851	162,704		162,704		162,704			6
7	Other (specify):*			26,405	26,405		26,405		26,405			7
8	**TOTAL General Services**	415,670	319,019	238,797	973,486		973,486		973,486			8
	B. Health Care and Programs											
9	Medical Director			32,975	32,975		32,975		32,975			9
10	Nursing and Medical Records	2,090,529	231,203	264,039	2,585,771	(50,856)	2,534,915		2,534,915			10
10a	Therapy	252,357	13,793	30,483	296,633		296,633		296,633			10a
11	Activities	24,960	26,169	10,577	61,706		61,706		61,706			11
12	Social Services	44,373			44,373		44,373		44,373			12
13	Nurse Aide Training		4,499		4,499	50,856	55,355		55,355			13
14	Program Transportation			56,790	56,790		56,790		56,790			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,412,219	275,664	394,864	3,082,747		3,082,747		3,082,747			16
	C. General Administration											
17	Administrative	98,590			98,590		98,590		98,590			17
18	Directors Fees											18
19	Professional Services			29,421	29,421		29,421	(5,929)	23,492			19
20	Dues, Fees, Subscriptions & Promotions			79,880	79,880		79,880		79,880			20
21	Clerical & General Office Expenses	270,568	131,187	60,382	462,137		462,137		462,137			21
22	Employee Benefits & Payroll Taxes			790,576	790,576		790,576		790,576			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,301	6,301		6,301		6,301			24
25	Other Admin. Staff Transportation			17,947	17,947		17,947		17,947			25
26	Insurance-Prop.Liab.Malpractice			60,886	60,886		60,886		60,886			26
27	Other (specify):* fund-raising/promo)			1,044,124	1,044,124		1,044,124	(1,044,124)				27
28	**TOTAL General Administration**	369,158	131,187	2,089,517	2,589,862		2,589,862	(1,050,053)	1,539,809			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,197,047	725,870	2,723,178	6,646,095		6,646,095	(1,050,053)	5,596,042			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Children's Home #0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			389,298	389,298		389,298	(112,478)	276,820			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			2,685	2,685	4,974	7,659	(7,659)				33
34	Rent-Facility & Grounds			49,109	49,109	(4,974)	44,135		44,135			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			441,092	441,092		441,092	(120,137)	320,955			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	250,536	83,430		333,966		333,966		333,966			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			308,096	308,096		308,096		308,096			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	250,536	83,430	308,096	642,062		642,062		642,062			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,447,583	809,300	3,472,366	7,729,249		7,729,249	(1,170,190)	6,559,059			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(112,478)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,929)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,044,124)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real Estate Taxes	(7,659)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,170,190)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,170,190)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Marklund Children's Home

ID# **0011288**

Report Period Beginning: **7/1/00**

Ending: **6/30/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Taxes on Rented site	$ (7,659)	33	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,659)		49

Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	0
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	(5,929)
Line 20	0
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	(1,044,124)
Line 28	(1,050,053)
Line 29	(1,050,053)
Line 30	(112,478)
Line 31	0
Line 32	0
Line 33	(7,659)
Line 34	0
Line 35	0
Line 36	0
Line 37	(120,137)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(1,170,190)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,929)	0	0	0	0	0	0	0	0	0	0	(5,929)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):* fund-raising/pron	(1,044,124)	0	0	0	0	0	0	0	0	0	0	(1,044,124)	27
28	**TOTAL General Administration**	(1,050,053)	0	0	0	0	0	0	0	0	0	0	(1,050,053)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,050,053)	0	0	0	0	0	0	0	0	0	0	(1,050,053)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Marklund Children's Home **#** 0011288 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(112,478)	0	0	0	0	0	0	0	0	0	0	(112,478)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(7,659)	0	0	0	0	0	0	0	0	0	0	(7,659)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(120,137)	0	0	0	0	0	0	0	0	0	0	(120,137)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,170,190)	0	0	0	0	0	0	0	0	0	0	(1,170,190)	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	N/A					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	3,374	8
	1997		9
	1998		10
	1999		11
	2000		12

Note: The taxable property that related to calendar year 1996 (see above) was sold in 9/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Children's Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0011288

CONTACT PERSON REGARDING THIS REPORT Lisa Lipira

TELEPHONE (630)529-2018 Ext. 2232 FAX #: (630)529-9128

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-14-301-031	90 bed facility-tax exempt	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	206,930	1968	$ 31,500	1
2					2
3	TOTALS	206,930		$ 31,500	3

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1968	1953	$ 68,500	$ 2,055	33	$ 2,055	$	$ 67,301	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pavillon land impr			1989	6,485	324	20	324		4,053	9
10	Landscaping land impr			1990	1,080	54	10	54		1,080	10
11	Asphalt Paving Land impr			1991	7,112					7,112	11
12	Asphalt Seal & Strip Parking Lot land impr			1994	14,893					14,893	12
13	Asphalt Land impr			1996	800	160	5	160		800	13
14	Seal & Repair Driveway Land impr			1998	600	120	5	120		300	14
15	Parking Lot Concrete Asphalt land impr			1999	300	60	5	60		90	15
16	Parking Lot Concrete Asphalt land impr			1999	32,199	6,440	5	6,440		9,660	16
17	Removal of ramp & installation of new land impr			1999	2,100	420	5	420		630	17
18	Parking Lot Concrete Asphalt land impr			2000	300	30	5	30		90	18
19	Resurface Playground land impr			2000	7,750	775	5	775		775	19
20	Sealcoat & Striping of Parking lot land impr			2000	3,187	319	5	319		319	20
21	Safety Surfacing of Playground			2000	6,094	609	5	609		609	21
22	Landscaping of Playground land impr			2000	3,325	333	5	333		333	22
23											23
24	Building Construction Pod II			1973	615,786	17,009	40	17,009		437,173	24
25	Oxygen Work			1974	74,064	2,047	40	2,047		50,516	25
26	Oxygen Work			1975	5,000	135	40	135		3,311	26
27	Oxygen Work			1976	7,535	188	40	188		4,850	27
28	New Roof			1986	81,000	4,050	20	4,050		62,775	28
29	Lobby Addition			1984	108,605	5,030	25	5,030		75,909	29
30	Parents Room			1987	42,000	2,100	20	2,100		28,350	30
31	Wall/Fire Door			1990	1,200	60	10	60		1,200	31
32	POD general renovations floors/walls			1992	22,173	1,826	10	1,826		20,759	32
33	Fire Alarm			1993	850	85	10	85		723	33
34	Oxygen System			1993	13,429	1,343	10	1,343		11,415	34
35	Carpeting			1995	2,984	298	10	298		1,940	35
36	Water Heaters			1995	8,916	892	10	892		3,121	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C Compressor	1995	$ 610	$ 61	5	$ 61	$	$ 610	37
38	Heating and A/C Unit	1995	16,685	1,669	5	1,669		16,685	38
39	Vinyl Tile	1995	644	64	10	64		354	39
40	Steel/Fire Doors	1995	1,255	126	5	126		1,255	40
41	Client Room Shelves	1995	1,431	143	5	143		1,431	41
42	Dental Office Cabinets	1996	4,165	417	5	417		4,165	42
43	Door/Frame Laundry Room	1996	845	85	5	85		845	43
44	Front Entry Door Controls	1996	2,120	212	5	212		2,120	44
45	Fire Alarm/Electric Repairs	1996	7,863	786	5	786		7,863	45
46	Boiler	1996	887	89	5	89		887	46
47	Painting/Carpeting	1996	7,792	447	5	447		7,568	47
48	Gutters, roof down spouts	1999	8,800	1,760	5	1,760		4,400	48
49	new compressor	1999	2,580	177	15	177		435	49
50	Awnings	1999	2,520	504	5	504		1,260	50
51	Boiler	1998	2,675	534	5	534		1,336	51
52	Lobby walls	2000	57	12	5	12		18	52
53	Awnings rear entrance	2000	2,023	404	5	404		606	53
54	lower level classroom renovations	2000	189	36	5	36		54	54
55	awning for O2 protection	2000	3,477	696	5	696		1,044	55
56	Lobby walls	2000	7,997	1,000	5	1,000		1,500	56
57	HVAC-dining room	2000	610	122	5	122		183	57
58	Dining room walls & wall coverings	2000	2,060	412	5	412		618	58
59	HVAC coil dining room	2000	1,590	318	5	318		477	59
60	Dining room flooring window shades	2000	3,560	712	5	712		1,068	60
61	fire doors lower level	2000	564	56	5	56		84	61
62	carpet flooring lower level	1999	5,855	1,170	5	1,170		1,755	62
63	lower level classroom renovation	1999	1,346	270	5	270		405	63
64	replacement windows	1999	538	108	5	108		162	64
65	Construction, engineering, architect, inspection	1999	49,390	4,940	10	4,940		7,410	65
66	fire sprinkler system	1999	72,843	2,914	25	2,914		4,371	66
67	interior design, handrails, corner pieces	1999	29,873	1,992	15	1,992		2,988	67
68	Demolition old lower level	1999	26,641	2,664	10	2,664		3,996	68
69	Chair rails	1999	8,160	1,632	5	1,632		2,448	69
70	TOTAL (lines 4 thru 69)		$ 1,415,912	$ 73,294		$ 73,294	$	$ 5,952	70

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,415,912	$ 73,294		$ 73,294	$	$ 5,952	1
2	Painting lower level	1999	19,835	3,968	5	3,968		5,952	2
3	lower level construction walls	1999	101,713	10,172	10	10,172		15,258	3
4	cabinets	1999	46,002	3,066	15	3,066		4,599	4
5	Reg. & auto doors	1999	18,259	1,826	10	1,826		2,739	5
6	Equip relocation	1999	2,495	500	5	500		750	6
7	Electrical work lower level	1999	29,697	2,970	10	2,970		4,455	7
8	windows/shutters	1999	15,523	3,102	10	3,102		4,653	8
9	Floor/carpeting	1999	46,503	9,301	5	9,301		13,951	9
10	Signage Interior/Exterior	1999	3,899	390	10	390		585	10
11	Plumbing lower level	1999	21,177	1,058	20	1,058		1,587	11
12	ECU Awnings	1999	3,994	266	15	266		399	12
13	Paneling	1999	7,309	1,462	5	1,462		2,193	13
14	Security System,Elevator	1999	11,010	734	15	734		1,101	14
15	New door hardware	1999	197	20	10	20		30	15
16	Fire alarm system upper level	1999	12,491	500	25	500		750	16
17									17
18	Water Heater	2001	767	77	5	77		77	18
19	Air Curtain	2001	764	76	5	76		76	19
20	Replacement Parts - Boiler	2001	5,290	529	5	529		529	20
21	Compressor Pump	2001	1,599	160	5	160		160	21
22	Security Door	2001	2,427	243	5	243		243	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,766,863	$ 113,714		$ 113,714	$	$ 66,039	34

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 690,855	$ 127,703	$ 127,703	$	5	$ 468,096	71
72	Current Year Purchases	69,738	8,035	8,035		5	8,035	72
73	Fully Depreciated Assets	234,089				5	234,089	73
74								74
75	TOTALS	$ 994,682	$ 135,738	$ 135,738	$		$ 710,220	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 Internat'l Bus	2000	$ 62,500	$ 12,500	$ 12,500	$	5	$ 18,750	76
77	Maintenance Use	2000 Isuzu Truck	2000	31,007	6,201	6,201		5	9,302	77
78	General Use	2000 4-dr Chrysler Sedan	2000	26,000	8,667	8,667		3	13,000	78
79										79
80	TOTALS			$ 119,507	$ 27,368	$ 27,368	$		$ 41,052	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,912,552	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 276,820	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 276,820	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 817,311	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Improvements (1990-2001)	$ 35,214	$ 4,289	$ 15,490	86
87	Build & Build Impr. (1990-2001)	729,988	43,992	402,595	87
88	Equipment (1990-2001)	145,091	20,670	109,216	88
89	Vehicles (1990-2001)	133,345	17,030	95,013	89
90	Leasehold Improvements	113,419	26,497	131,419	90
91	TOTALS	$ 1,157,057	$ 112,478	$ 753,733	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Berkson & Sons, Ltd.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	0	4/96	$ 44,135	5	5	3
4	Additions							4
5								5
6								6
7	TOTAL				$ 44,135 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/00
Ending 5/05

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2002	$ 39,135
13.	6/30/2003	$ 40,371
14.	6/30/2004	$ 41,582

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,169 Description: Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE 87

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE 44

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	810	3,689		4,499
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	9,154	41,702		50,856
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 9,964	$ 45,391	$	$ 55,355
10	SUM OF line 9, col. 1 and 2 (e)	$ 55,355			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	46
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	
TOTAL TRAINED	56

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	line 39, Col. 8	11,388 hrs.	250,536			83,430	11,388	333,966	12
13	Other (specify):									13
14	TOTAL			$ 250,536		$	$ 83,430	11,388	$ 333,966	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,060,657	$ 2,060,657	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 61,500)	2,200,630	2,200,630	3
4	Supply Inventory (priced at Cost)	47,355	47,355	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	94,498	94,498	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client related funds	456,714	456,714	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,859,854	$ 4,859,854	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,082,158	4,082,158	13
14	Buildings, at Historical Cost	5,550,716	5,550,716	14
15	Leasehold Improvements, at Historical Cost	319,570	319,570	15
16	Equipment, at Historical Cost	3,454,231	3,454,231	16
17	Accumulated Depreciation (book methods)	(5,898,568)	(5,898,568)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,397,506	10,397,506	21
22	Other Long-Term Assets (spe Board Restr.	879,338	879,338	22
23	Other(specify): Construction in Progress	694,818	694,818	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 19,479,769	$ 19,479,769	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,339,623	$ 24,339,623	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 480,629	$ 480,629	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,578	191,578	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,076	15,076	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Other Accrued	2,010,110	2,010,110	36
37	Client related liability	456,714	456,714	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,154,107	$ 3,154,107	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,154,107	$ 3,154,107	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 21,185,516	$ 21,185,516	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,339,623	$ 24,339,623	48

***(See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,516,486	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,516,486	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,977,326)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	4,752,251	11
12	Expenditures for Specific Purposes	(74,077)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaining Consolidated Income**	1,307,743	15
16	Other (describe) **Change in Unrealized Gains/(loss)**	(339,561)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,669,030	17
	B. Transfers (Itemize):		
18			18
19	**Trf out of Restricted Funds into Operations-expenses**	(92,880)	19
20	**Trf out of Restricted Funds into Operations-PP&E**	(2,891,297)	20
21	**Trf into Operations from Restricted-expenses**	92,880	21
22	**Trf into Operations from Restricted-PP&E**	2,891,297	22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 21,185,516	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,694,937	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,694,937	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	29,609	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10,830	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,439	23
	D. Non-Operating Revenue		
24	Contributions	11,180	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,180	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine/Cafeteria	5,367	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,367	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,751,923	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	973,486	31
32	Health Care	3,082,747	32
33	General Administration	2,589,862	33
	B. Capital Expense		
34	Ownership	441,092	34
	C. Ancillary Expense		
35	Special Cost Centers	333,966	35
36	Provider Participation Fee	308,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,729,249	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,977,326)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,977,326)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 59,173	$ 28.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,205	20,216	417,532	20.65	3
4	Licensed Practical Nurses	9,807	10,323	173,372	16.79	4
5	Nurse Aides & Orderlies	115,115	121,173	1,440,452	11.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,387	1,460	29,994	20.54	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,755	1,847	24,960	13.51	10
11	Social Service Workers	2,964	3,120	44,373	14.22	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	34,320	16.50	13
14	Head Cook	2,766	2,912	35,861	12.31	14
15	Cook Helpers/Assistants	7,546	7,943	92,240	11.61	15
16	Dishwashers	1,976	2,080	24,155	11.61	16
17	Maintenance Workers	3,829	4,031	74,969	18.60	17
18	Housekeepers	12,162	12,802	103,617	8.09	18
19	Laundry	5,928	6,240	50,508	8.09	19
20	Administrator	3,193	3,361	98,590	29.33	20
21	Assistant Administrator					21
22	Other Administrative	13,178	13,871	270,568	19.51	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,031	10,559	150,478	14.25	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	6,086	6,406	71,885	11.22	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) RN-Exceptl Care	10,819	11,388	250,536	22.00	33
34	TOTAL (lines 1 - 33)	231,699	243,892	$ 3,447,583 *	$ 14.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	331	$ 15,228	1	35
36	Medical Director	Monthly	32,975	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	28	1,673	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	549	28,810	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Recreational Ther.	124	3,720	11	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,032	$ 82,406		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	12,089	264,039	10	52
53	TOTAL (lines 50 - 52)	12,089	$ 264,039		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Bowen-Weyrich	Adm. Support		$ 48,600
Tara McKenney	Administrator		49,990
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 98,590

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	Audit Fees	$ 9,964
Huck Bouma & Martin,		
Fenech & Pachulski, P.C.	Legal Fees	19,457
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 29,421

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,575
Unemployment Compensation Insurance	14,633
FICA Taxes	263,740
Employee Health Insurance	263,389
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	146,975
Dental Plan	21,196
Life Insurance	2,068
TOTAL (agree to Schedule V, line 22, col.8)	$ 790,576

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	66,258
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	4,068
Misc. Licenses and Permits	2,136
Misc. Dues and Subscriptions	7,418
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,301
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,301

**See instructions.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/00 Ending: 6/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $4,068**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **98**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **95,895** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **308,096**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **15%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2001
Schedule V. Cost Center Expenses

Line #10 & Line #13

Reclassification:

Wages for the in-house trainer for our Nurses Aide Training Program: $50,856.00

(This is also reflected on Schedule XIII. Expenses relating to Nurse Aide Training Program)

Line # 33 & Line #34

Reclassification:

Real Estate Taxes reclassed from Rent-Facility to Real Estate Taxes - based on Schedule XII. Rental Costs instructions related to Section A., question #2 $4,974.00

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2001
Schedule XX. General Information

Line #14.

There is minimal space, (one classroom), that is rented to NDSEC for day school for some of our clients. There are no costs associated with this. NDSEC supplies their own teachers and supplies, etc. We generate minimal income for the rental of this room.

See Schedule XVII., Line #16.

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2001
Schedule XIX. Section C.
Summary of Legal Services

Check #	Amount	Personnel	General Business
77261	$1,945.90	$1,505.00	$440.90
79445	$198.00	$198.00	
80352	$619.75	$619.75	
80923	$5,839.38		$5,839.38
81614	$1,453.60		$1,453.60
81726	$2,172.80		$2,172.80
82069	$1,298.40		$1,298.40
Totals	**$13,527.83**	**$2,322.75**	**$11,205.08**

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2001
Schedule XIX. Section G.
Seminars

NAMES	JOB TITLES	DATE	LOCATION OF SEMINAR	SPONOR/TITLE	AMOUNT
AMADA AMAYA	DIETARY AIDE	AUG 28&29/00	NAPERVILLE	PALADIN MANAGEMENT	$199.00
AUTURO CASER	DIETARY AIDE	AUG 28&29/00	NAPERVILLE	PALADIN MANAGEMENT	$199.00
CHRISTINE FEDEROWITZ	THERAPEUTIC ACTIVITY AIDE	10/26/2000	RIVER GROVE	TRITION COLLEGE	$75.00
RON NEECE	REC THERAPIST/QMRP	9/29/2000	AURORA	AURORA UNIVERSITY	$55.00
NANCY RODRIGUEZ	ASSISTANT ADMINISTRATOR	10/12/2000	PALENTINE	CAREER TRACK	$79.00
PAT PETERMAN	SOCIAL SERVICES MANAGER	10/12/2000	PALENTINE	CAREER TRACK	$79.00
CHERL VALDEZ	DIRECTOR SUPPORT SERVICES	10/6-7/00	EFFINGHAM	LINCOLN TRAIL WORKSHOP	$75.00
TERRI BOWEN-WEYRICH	VICE PRESIDENT	9/14/2000	CHICAGO	UIC/DHD	$75.00
KRIS PIROK	MEDICAL RECORDS COORDINATIOR	9/12/2001	ELMHURST	MEDICAL EDUCATION	$130.00
EMILY JOHNSON	QMRP	9/29/2000	AURORA	AURORA UNIVERSITY	$55.00
TARA MCKENNIE	ACTING ADMINISTRATOR	10/17-18/00	CHICAGO	STAFF TRAINING	$189.00
TERRI BOWEN-WEYRICH	VICE PRESIDENT	Nov-00	BLOOMINGDALE	COD-TEAM BUILDING	$75.00
TARA MCKENNIE	ACTING ADMINISTRATOR	12/2&9/00	ST.CHARLES	ILLINOIS HEALTH CARE	$275.00
KRIS PIROK	MEDICAL RECORDS COORDINATIOR	2/28/2001	BLOOMINGDALE	COD-TEAM BUILDING	$75.00
PAT PETERMAN	SOCIAL SERVICES MANAGER	1-Nov	BLOOMINGDALE	COD-TEAM BUILDING	$115.00
HOLLY MARCALIC	PM NURSE	Nov-00	BLOOMINGDALE	COD-TEAM BUILDING	$115.00
RON NEECE	THERAPEUTIC ACTIVITY AIDE	12/1/2000	LISLE	RAY GRAHAM	$260.00
IRENE KASNICKA	DON, MCH	12/18/2000	BLOOMINGDALE	PULMONARY EXHANGE	$90.00
TARA MCKENNIE	ACTING ADMINISTRATOR	1/18/2001	LOMBARD	NDC, HEALTH	$135.00
MARY CHOW	NIGHT NURSE	2/3/2001	GLEN ELLYN	COD	$55.00
CHERL VALDEZ	DIRECTOR SUPPORT SERVICES	1-Jan	BLOOMINGDALE	COD-TEAM BUILDING	$113.00
NANCY RODRIGUEZ	ASSISTANT ADMINISTRATOR	1-Jan	BLOOMINGDALE	COD-TEAM BUILDING	$114.00
JALPA PANDYA	PHYSICAL THERAPIST	2/22-26/00	GLENVIEW	PATH WAY	$134.71
MARY KALTINGER	NURSING SUPERVISOR	2/23/2001	SCHUAMBERG	PESI	$135.00
AGNES GRAM	P.M NIGHT SUPERVISOR	2/23/2001	SCHUAMBERG	PESI	$135.00
RON NEECE	REC THERAPIST/QMRP	2/19/2001	ELK GROVE	FRED PYOR	$159.00
VICKY CORRIGAN	PHYSICAL THERAPIST ASST.	2/19/2001	ELK GROVE	FRED PYOR	$159.00
RON NEECE	REC THERAPIST/QMRP	2/28/2001	NAPERVILLE	SKILL PATH	$199.00
IRENE KASNICKA	DON, MCH	2/3/2001	GLEN ELLYN	COD	$55.00
MARY KALTINGER	NURSING SUPERVISOR	2/3/2001	GLEN ELLYN	COD	$55.00
KEVIN O'BRIAN	NURSING SUPERVISOR	2/3/2001	GLEN ELLYN	COD	$55.00
TERRI BOWEN-WEYRICH	VICE PRESIDENT	3/8/2001	ST.CHARLES	WESSEL & PAUTSCH	$80.00
JALPA PANDYA	PHYSICAL THERAPIST	3/15-19/01	GLENVIEW	PAHTWAY	$203.82
MYRA BERTLING	QMRP	4/23-25/02	ST. LOUIS, MO	MIDWEST SYMOSIUM	$110.00
CHERL VALDEZ	DIRECTOR SUPPORT SERVICES	5/4&5/01	GALENA	ILLINOIS DMA	$75.00
JALPA PANDYA	PHYSICAL THERAPIST	4/6-9/01	GLENVIEW	PATH WAY	$203.82
TARA MCKENNIE	ASSISTANT ADMINISTRATOR	1-Apr	BLOOMINGDALE	COD-TEAM BUILDING	$100.00
TARA MCKENNIE	ASSISTANT ADMINISTRATOR	4/11&12/01	SPRINGFIELD	IHCA	$30.68
CHERL VALDEZ	DIRECTOR SUPPORT SERVICES	5/4&5/01	GALENA	ILLINOIS DMA	$100.00
IRENE KASNICKA	DON, MCH	4/18/2001	BLOOMINGDALE	PULMONARY EXHANGE	$105.00
JALPA PANDYA	PHYSICAL THERAPIST	5/18-22/01	GLENVIEW	PATH WAY	$203.82
TARA MCKENNIE	ASSISTANT ADMINISTRATOR	6/26/2001	SPRINGFIELD	AHCA	$225.00
DIANA BOOK	DIRECTOR SUPPORT SERVICES	1-Jun	WINFIELD	SANITATION MATERIALS	$31.89
CHRISTINE FEDEROWITZ	THERAPEUTIC ACTIVITY AIDE	6/8/2001	CHICAGO	CROSS COUNTRY	$159.00
VICKY CORRIGAN	PHYSICAL THERAPIST ASST.	6/9-10/01	CHICAGO	THERAPUTIC SERVICE	$350.00
JALPA PANDYA	PHYSICAL THERAPIST	6/8-12/01	GLENVIEW	PAHTWAY	$203.82
TERRI BOWEN, TARA MCKENNIE	ADMINISTRATOR, SUPPORT	7/21-25/00	SPRINGFIELD	IHCA	$400.00
					$6,300.56

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2001
Schedule XII.
Listing of Movable Equipment

Description	Quantity
Minolta Fax 2600	2
Minolta 6001 Copier	2

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2001
Schedule VI. Adjustment Detail

Line #29

Adjustment: Non-Allowable

Real Estate Taxes:	$7,659.00